

**DISCLOSURE INFORMATION FOR CHARACTER AND COMPETENCY REVIEW  
 PERSONAL QUALIFYING INFORMATION  
 (See Instructions For Completion of HMO/PSHP Certification Application,  
 Section I. ORGANIZATION AND MANAGEMENT, B-1)**

**A. PERSONAL IDENTIFYING INFORMATION**

NAME (Last) (First) (Middle Initial)

MAILING ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER

( )  
 DATE OF BIRTH (Month / Day / Year) PLACE OF BIRTH (County / State) SOCIAL SECURITY NUMBER

CURRENT OR PROPOSED POSITION WITH PROPOSED HMO/PHSP

**B. INDIVIDUAL EMPLOYMENT HISTORY**

Start with MOST RECENT employment and include employment for the last 10 years. A resume may be included but any additional information requested below and not contained in such a resume should be added. Photocopy and attach additional sheets if necessary.

NAME OF EMPLOYER:	
STREET ADDRESS OF EMPLOYER	
CITY	STATE ZIP CODE
DATES OF EMPLOYMENT from: to:	TYPE OF BUSINESS
NAME OF SUPERVISOR OR REFERENCE	TELEPHONE NUMBER (area code)
RESPONSIBILITIES	
REASON FOR DEPARTURE	

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Name: \_\_\_\_\_

SSN \_\_\_\_\_

**B. INDIVIDUAL EMPLOYMENT HISTORY (CONTINUED)**

NAME OF EMPLOYER:		
STREET ADDRESS OF EMPLOYER		
CITY	STATE	ZIP CODE
DATES OF EMPLOYMENT from:                      to:	TYPE OF BUSINESS	
NAME OF SUPERVISOR OR REFERENCE	TELEPHONE NUMBER (area code)	
RESPONSIBILITIES		
REASON FOR DEPARTURE		

NAME OF EMPLOYER:		
STREET ADDRESS OF EMPLOYER		
CITY	STATE	ZIP CODE
DATES OF EMPLOYMENT from:                      to:	TYPE OF BUSINESS	
NAME OF SUPERVISOR OR REFERENCE	TELEPHONE NUMBER (area code)	
RESPONSIBILITIES		
REASON FOR DEPARTURE		

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**C. LICENSES**

Type of License (including specialty)	Institution Granting License and Address	Date Received	Date of Expiration

**D. EDUCATIONAL HISTORY** *(High School and Subsequent Education)*

Institution	Address	Dates Attended	Degree	Date Received

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SSN \_\_\_\_\_

**E. HISTORY OF ANY LEGAL ACTIONS**

1. Have you ever changed your name or used an alias?

YES       NO

NOTE: If "YES," attach an explanation including other names(s) date(s) and the reason(s) for each change.

2. Except for minor traffic violations, have you ever been indicted or been convicted or had a sentence imposed or suspended, or been pardoned of a conviction for any crime?

YES       NO

3. Are there any criminal actions pending against you?

YES       NO

4. Have you ever been named as defendant in any civil action or proceeding in which there was an issue of moral turpitude, including but not limited to fraud or breach of fiduciary responsibility?

YES       NO

**NOTE: If "YES," to 2, 3, or 4, attach explanation(s) including the date of the action or proceeding, place (county of the filing), the civil docket number, if available, and the disposition of the case, if any.**

5. Have you ever been an officer, director, trustee, management employee or controlling stockholder of a company which, while you occupied any such position or served in any such capacity with respect to it:

a. became insolvent, declared or was forced to declare bankruptcy or was placed in receivership or conservatorship?

YES       NO

b. was enjoined from or ordered to cease and desist from violating any securities, insurance or health law or regulation?

YES       NO

c. suffered the suspension or revocation of its certificate of authority or license to do business in any

state?

YES       NO

d. was denied a certificate of authority or license to do business in any state?

YES       NO

NOTE: if "yes", to any of the above, attach an explanation.

6. During the last 10 years, have you been refused a professional occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has such a license held by you during such period ever been suspended or revoked?

YES       NO

7. Have you ever been named as a defendant in an action or proceeding brought by any public or governmental licensing agency or regulatory authority for violation of, or to prevent the violation of, any securities, insurance or health law or regulation?

YES       NO

NOTE: If "YES," to number 6 or 7 above, attach an explanation.

8. Have you ever been in a position that required a fidelity bond?

YES       NO

a. If "YES", were any claims made against the bond?

YES       NO

b. Have you ever been denied a fidelity bond or had such fidelity cancelled or revoked?

YES       NO



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**F. AFFILIATION WITH OTHER HEALTH CARE OPERATIONS**

(See General Instructions, I. ORGANIZATION AND MANAGEMENT, B-1 (F))

1. For the past 10 years, have you owned or operated any health care or health related operations or held a management position or had any affiliations with health care or health related operations in New York, in the USA or in other countries?

YES       NO

**NOTE:** If "YES," complete the following chart:

Name and Address of Health Care Operation	Affiliation Dates From/To	Nature of Affiliation with Facility	Licensing Agency	License Number

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**F. AFFILIATION WITH OTHER HEALTH CARE OPERATIONS** (continued)

2. Are/were these facilities in compliance with applicable laws and regulations during your affiliation?

YES       NO

NOTE: If "NO," complete the following:

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING VIOLATION (name and address)

STEPS TAKEN BY FACILITY TO REMEDY VIOLATION

HAS SUSPENSION, REVOCATION OR ACCREDITATION SINCE BEEN RESTORED?     YES     NO

NOTE: If "NO", explain below.

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SSN \_\_\_\_\_

**G. PERSONAL FINANCIAL INVOLVEMENT IN HMO/PHSP**

**1. Financial Support for the Proposed HMO/PHSP**

Is the applicant, owner, all members of a partnership or officers, directors and controlling persons of for profit and not-for-profit corporations or other business corporations intending to provide capital for use in owning, organizing or operating proposed HMO/PHSP? (Controlling person means any person who has the ability, directly or indirectly, to direct or cause the direction of the management or policies of a corporation, partnership or other entity.)

YES       NO

**NOTE:** If "YES," provide the following:

- Attach a personal financial statement for each individual providing financial support from personal finances for the proposed HMO/PHSP.
- Make clear the percent of the business which each person controls, and document its value.
- Lessors are to attach documents showing their financial ability to fulfill any construction obligations.
- Any additional information pertinent to determination of either the applicant's financial capabilities or the project's feasibility must also be attached.
- For a change in ownership control, submit affidavits from both the applicant and the party from which the operational interest is being acquired. Interest, for the purposes of this section, means right, title or share in a facility, participation in any advantage, profit and responsibility from or for the facility.

**2. Stock Ownership or Stock Options**

Do you or a relative own stock or options to purchase stock in the proposed HMO/PHSP, the holding company or any subsidiaries of the holding company? Relative, for the purposes of this section, includes each parent, child, spouse, brother or sister whether such relationship arises by reason of birth or adoption.

YES       NO

**NOTE:** If "Yes," complete the stock ownership and stock option form below:

**STOCK OWNERSHIP/STOCK OPTIONS FORM**

NAME	POSITION	ORGANIZATION
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Name and Type of Business	Class of Security	# of Shares or Options	% of Total Shares or Options	Market Value	Owner	If pledged, To Whom

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Name: \_\_\_\_\_

SSN \_\_\_\_\_

**3. Transactions with the Proposed HMO/PHSP or Holding Company**

Have any transactions involving money, extension of credit, loans, notes, bonds or mortgages occurred or are such transactions anticipated between the proposed HMO/PHSP and you or any of your relative(s) or between the holding company and you or any of your relatives(s)?

YES       NO

**NOTE:** If "Yes", complete the Disclosure of Transactions Form below identifying such transactions

**DEFINITIONS:**

**RELATIVE**, for the purposed of this section, includes each parent, child, spouse, brother or sister whether such relationship arises by reason of birth or adoption.

**TRANSACTION**, for the purposes of this section, is any business transaction or series of transactions which during any one fiscal year, represents 5 percent of the total annual operating expenses of any of the parties to the transaction. Transactions include any sale or leasing of any property. Salaries paid to employees for services provided in the normal course of their employment are not included in this definition. No single transaction of less than \$500 need be reported.

**DISCLOSURE OF TRANSACTIONS FORM**

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PARTIES INVOLVED IN TRANSACTION

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TYPE OF TRANSACTION

---

VALUE OF TRANSACTION

PERCENT OF OPERATING COSTS/

DOLLARS

PERCENT INTEREST RATE/

DOLLARS

REASON FOR TRANSACTION

---

METHOD OF REPAYMENT

---

PARTIES INVOLVED IN TRANSACTION

---

TYPE OF TRANSACTION

---

VALUE OF TRANSACTION

PERCENT OF OPERATING COSTS/

DOLLARS

PERCENT INTEREST RATE/

DOLLARS

REASON FOR TRANSACTION

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METHOD OF REPAYMENT

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(Attach additional sheets if necessary)

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**AFFIDAVIT**

State of \_\_\_\_\_

County of \_\_\_\_\_

I, \_\_\_\_\_ being duly sworn deposes and says I am a  
*NAME (Last, first, middle initial)*

proposed \_\_\_\_\_ of  
*POSITION*

\_\_\_\_\_  
*ORGANIZATION/CORPORATION*

I certify that I have provided all the information requested in NYS DOH Form DOH-793C, Sections A-G including a complete list of any and all hospitals, nursing homes, clinics, health maintenance organizations, halfway houses, hotels, other institutions of care, operations involving the custody or treatment for the physically or mentally afflicted within the past 10 years as an operator, owner, incorporator, director, partner, medical director or stockholder with 10 percent or more total shares.

I certify, under penalty of perjury, that if no names of such health care operations have been provided, I have had no such affiliations in the past 10 years and that the information contained herein is accurate, true and complete.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Subscribed and sworn to before me this  
\_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_

Name of Notary Public \_\_\_\_\_

Signature of Notary Public \_\_\_\_\_